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No. 07-1434

IN THE

Supreme Court of the United States

DIXIE NATIONAL LIFE INSURANCE COMPANY AND NATIONAL FOUNDATION LIFE INSURANCE COMPANY,
Petitioners,

v.

MARTHA WARD, ON BEHALF OF HERSELF AND ALL OTHERS SIMILARLY SITUATED,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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MOTION OF THE SOUTH CAROLINA DEPARTMENT OF INSURANCE FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Rule 37 of the rules of this Court, the South Carolina Department of Insurance ("DOI") requests leave to file the accompanying brief as *amicus curiae* in support of the petition for writ of certiorari.

Petitioner's consent has been filed with the Clerk of Court; Respondent did not consent to the filing of this brief. All parties received timely notice of the DOI's intent to file a brief as *amicus curiae*.

This case presents the Court with the important question of whether the federal courts should insert themselves into a state law dispute an between insurers and its policyholder when the state insurance regulatory agency has issued its opinion to resolve that dispute. The United States Court of Appeals for the Fourth Circuit did just that, negating the ruling of the South Carolina Department of Insurance, a decision that the DOI had a statutory duty to make.

Full review of the judgment below is essential. The Fourth Circuit's decision stands federalism on its head by refusing to defer to the decision of a state agency exercising its statutory duty in a field that Congress has left to the states.

The DOI is the state agency directly affected by the Fourth Circuit's decision. Accordingly, the DOI respectfully requests that this Court grant its motion for leave to file the accompanying brief as amicus curiae in support of the Petitioner.

Respectfully submitted,

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QUESTION PRESENTED

Whether the Fourth Circuit erred by rejecting the interpretation of a South Carolina insurance policy by the South Carolina Department of Insurance, when South Carolina law has imbued that state agency with the authority and a statutory duty to approve and interpret that policy.

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INTRODUCTION AND SUMMARY OF ARGUMENT [1]

In this case, the United States for the Fourth Circuit rewrote a supplemental cancer insurance policy. In so doing, the court of appeals threw the

[1] Counsel for a party has not authored this brief, nor has any person or entity made any monetary contribution intended to fund the preparation or submission of this brief.

market for supplemental disease policies in South Carolina into turmoil. The South Carolina Department of Insurance had approved the policy language based on its statutory duty to approve policy forms and reaffirmed its interpretation of that language in the course of exercising its statutory duty to regulate the claims practices of South Carolina insurers. The Fourth Circuit's decision unnecessarily and wrongly usurps the statutory authority of a duly constituted executive agency of the government of South Carolina.

Review of the court of appeals' decision is essential. If the holding is not reversed, the legal authority and statutory duty of the South Carolina Department of Insurance to enforce the insurance laws of South Carolina will be impaired significantly. Federal courts must defer to states in the construction of state laws and to regulatory agencies with regard to the construction of the laws that those agencies must enforce. The Fourth Circuit's failure to afford any deference whatsoever to the state of South Carolina and to its insurance regulatory agency in the construction of South Carolina insurance law will create uncertainty for the public and for the insurance industry. From a public policy perspective, the market for supplemental disease insurance policies in the state will be severely affected, pricing many, if not most, consumers out of that market.

ARGUMENT

I. The Fourth Circuit Improperly Refused to Accord the Appropriate Deference to a State Agency's Reasoned Interpretation of the Policy Pursuant to the State Statutes the Agency is Charged with Enforcing

In response to the complaints of Mrs. Ward and others, the South Carolina Department of Insurance (DOI), pursuant to its statutory duty to investigate insurers' claims practices, *see* S.C. Code Ann. § 38-59-10, -20 (2002), determined that the insurer properly adjusted and paid "actual charge" benefits under Mrs. Ward's supplemental cancer policy. Based upon, among other things, (i) the clear and unambiguous terms of the policy, (ii) the arguments of Mrs. Ward and other policyholders, (iii) the insurer's explanation of its claim payment procedures, and (iv) fundamental insurance principles, the DOI determined that "actual charges" in Mrs. Ward's policy means the charge the insured is legally obligated to pay a health care provider for its services.[2] The DOI concluded that when a health care provider's invoice or billing statement reflects an amount higher than a provider has agreed, in advance of providing services, to accept from an insured's primary health insurer (*e.g.*, Medicare) as payment in full, an insured is not entitled to receive insurance benefits based upon a higher amount reflected on the provider's invoice because that amount is not an "actual charge." The

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[2] Under a group health insurance policy, the insured is actually the group, and individuals are beneficiaries. For consistency and ease of reference, the DOI refers to beneficiaries as "insureds" in this brief.

provider's "actual charge" is the amount of money that the provider negotiated and agreed to accept as payment in full for its services. It is the money that changed hands to pay the provider.

In finding that the term "actual charges" in Mrs. Ward's cancer policy is ambiguous and "could also be understood to mean the amount shown on the bill sent to the patient regardless of whether this amount is the same as the amount actually owed," Slip Op. at 10-11, the Fourth Circuit necessarily concluded that the cancer policy requires the insurer to pay benefits to Mrs. Ward greater than the amount her health care providers negotiated and actually received as payment in full.[3] In so doing, the Fourth Circuit disregarded the express and unambiguous language of the insurance policy. Neither Mrs. Ward nor her primary health insurer was ever obligated to pay her health care providers the largest sums shown on the providers' invoices, and the health care providers never expected to collect those amounts.

Because Mrs. Ward is not required to pay – and did not pay – the sums she seeks under her policy, she has suffered no loss. The policy expressly provides that it only pays covered benefits when the insured suffers a "covered loss." Any insurance payment for a sum greater than the amount of money actually paid

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[3] The Court of Appeals correctly notes that certain health care dictionaries define "actual charges" as an amount "billed" by a health care provider. This definition is wholly consistent with the Department's position. A bill is an invoice. It sets forth an amount for which a customer, insured, or insurance company is liable. Creditors do not "bill" their debtors for amounts those debtors do not owe. In the context of this case, the amount billed is the amount the provider is legally entitled to collect – that is, the actual charge.

to a provider, therefore, would not indemnify Mrs. Ward; rather, it would be a windfall for Mrs. Ward. Insurance, however, indemnifies policyholders for covered losses; it does not bestow windfalls on insureds. The DOI thus concluded that the term "actual charges" is not ambiguous and means what it says: the charges actually and legally owed to a health care provider. Paying to receive a chance for a windfall is gambling, not insurance.

The Fourth Circuit's decision negates the DOI's reasoned determination, undermines its authority, and impairs its statutory duty. In South Carolina, the DOI is vested with broad authority to review, interpret and approve insurance contracts and their attendant premiums. *See* S.C. Code Ann. §§ 38-3-310(A)(2) (2002). Health insurers must file their policy forms with the DOI, and the DOI must approve those forms before the insurers may use them. *See* S.C. Code Ann. 38-71-720(A) (Supp. 2007). The DOI may disapprove the form if it contains a provision that it determines to be ambiguous. *See id.* § 38-71-720(A)(2). By approving the form, the DOI determined that the term "actual charges" was not ambiguous.

Group health insurers, such as the insurer in this case, are required by South Carolina law to maintain minimum reserves to pay claims. *See* S.C. Code Ann. Regs. 69-7 (2007). Were the term "actual charges" intended to mean anything other than the sum of money paid by a primary health insurer, or by the insured, to a health care provider, the DOI would have considered the claims reserves inadequate and the premiums too low for the much greater liabilities that interpretation would have created for supplemental disease insurers.

The South Carolina legislature has also given the DOI the broad authority to regulate the claims practices of South Carolina insurers. *See* S.C. Code Ann. §§ 38-59-20, -30 (2002). The DOI cannot exercise this authority without the concomitant authority to interpret disputed provisions of insurance policies. Mrs. Ward's complaint to the DOI was, in essence, that the insurer was engaging in an unfair claims practice by "misrepresenting . . . policy provisions" and failing "to pay or settle claims in full." S.C. Code Ann. §§ 38-59-20(1), (8). It was this statute that empowered the DOI to decide that the insurer was not misconstruing its policy. And it was this statute that the Fourth Circuit ignored and subverted.

The DOI's decision, made pursuant to its statutory authority, that "actual charges" means the money actually paid to a provider must be "accorded the most respectful consideration and [should] not be overruled absent compelling reasons." *See Dunton v. South Carolina Bd. of Exam'rs in Optometry*, 353 S.E.2d 132, 133 (S.C. 1987). No such compelling reasons exist in this case. The Fourth Circuit's decision does not articulate any reason, much less a compelling reason, for disregarding and subverting the DOI's determination.

This case involves an issue of significant public policy import. It calls into question the actions of the South Carolina Department of Insurance in approving the words and terms of an insurance policy and in interpreting those words and terms in response to a consumer's complaint. It is precisely the type of issue upon which a state insurance regulatory body not only *should* opine, but upon which it *must* opine. If the court of appeals' decision is allowed to stand, the Court would create a dangerous precedent. Such a

decision will send a message to both consumers and insurers in South Carolina that the DOI's approval of insurance policy forms and its policy interpretations are untrustworthy. Such a decision will discourage consumers from seeking the DOI's assistance in resolving claims disputes with their insurance companies – that is, seeking the DOI's intervention to enforce the insurance laws of South Carolina.

To avoid that result, courts must apply traditional notions of comity and judicial deference to regulatory agency interpretations. The Fourth Circuit did not do so. Federal courts must not disrupt or undermine a coherent state regulatory scheme wisely designed to protect and serve consumers and the public interest, as the United States Court of Appeals for the Fourth Circuit did.

II. The Fourth Circuit Opinion Will Harm Consumers And The Insurance Marketplace in South Carolina

Unlike the typical insurance policy construction cases routinely decided by courts, this is not a case in which a court determined that a single claim was or was not covered by a policy. Rather, this is a case in which a court changed the very essence of a policy by vastly increasing the liability of every insurance company that has issued that type of policy in South Carolina. In so doing, the Court of Appeals greatly increased the costs associated with supplemental disease policies in South Carolina, for insurers and, especially, for the majority of insureds under those policies who are not members of the class certified by the district court.

The Fourth Circuit's decision will cause a significant increase in health insurance premiums in South

Carolina. The cancer policy at issue provides coverage to hundreds of South Carolina citizens, the vast majority of whom are not members of the class and will recover nothing if Mrs. Ward prevails. If the Fourth Circuit's decision is not overturned and Mrs. Ward prevails in the district court on remand, all insureds under this cancer policy will see their premiums rise to account for the additional sums that the insurer in this lawsuit would be required to pay and for all "actual charge" claims it would pay going forward. Every other insurer with a policy that pays benefits for health care providers' "actual charges" will be forced to raise premiums to pay claims based upon whatever amounts providers decide to put on their invoices. Indeed, not long after the Fourth Circuit issued its opinion, the DOI began receiving requests for substantial rate increases from supplemental disease insurers.

Considering the skyrocketing increases in health care costs, should Mrs. Ward prevail, hundreds, and potentially thousands, of South Carolinians will be unable to maintain their health insurance coverage, either because they could not afford their portion of their employers' premiums, or because their employers find themselves priced out of the market and cease offering health insurance. Moreover, given that insurers would be required to pay "actual charge" benefits even when an insured has not suffered a loss, insurers will invariably lose the financial incentive to write health insurance policies in South Carolina. This case, therefore, may result in increased benefits for a handful of policyholders, but those benefits will be vastly outweighed by the proportional – and perhaps disproportional – decrease in the availability of affordable cancer and similar

supplemental health insurance for all South Carolina consumers.

CONCLUSION

For these reasons, amicus asks the Court to grant the petition.

Respectfully submitted,

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